

General Information  
STD Clinicians UPDATE 2007

DATE: October 25, 2007

LOCATION: Ala Moana Hotel  
410 Atkinson Dr.  
Honolulu

REGISTRATION FEE: \$125 [physicians] and \$75 [non-physicians] (includes continental breakfast; luncheon; refreshments; and conference materials).

Make check payable to: **UNIVERSITY OF HAWAI'I**. Mail payment with the registration form and "Application for Training" form to: University of Hawai'i Conference Center; 2530 Dole St., C403; Honolulu, HI 96822.

DEADLINE: Deadline for advance registrations is October 12, 2007. Form of payment must accompany the registration. Credit card numbers submitted with registration will be processed upon receipt. Registrations will not be processed without payment.

Government and company purchase orders with authorized signature will be accepted and must accompany the registration form. Participants registering by purchase order will be billed for nonattendance unless notification of withdrawal is made by October 19, 2007.

REFUNDS: Requests for refunds will be received at the UH Conference Center by October 19 in writing. No refunds will be made thereafter. Refunds will be mailed. Please allow approximately three to five weeks for processing.

ACCESSIBILITY ASSISTANCE: If you would like assistance due to a mobility, hearing or sight impairment, you are warmly encouraged to contact the Conference Center at 956-8204 by September 21, 2007.

PARKING: Validated parking is available in the hotel garage for \$2.00 per day.

PLEASE DIRECT ALL REGISTRATION INQUIRIES TO:  
UH Conference Center at (808) 956-8204. Fax. No. (808) 956-3364

## REGISTRATION FORM

### STD Clinicians Update 2007

Feel free to copy this form for additional registrations  
Please **print or type**.

Name: \_\_\_\_\_  
Last First

Affiliation: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City State Zip code

Phone: \_\_\_\_\_  
business fax

Email address: \_\_\_\_\_

\*\*\*\*\*

Luncheon choice: \_\_\_Standard or \_\_\_Vegetarian

Accessibility assistance: See general information

\*\*\*\*\*

Registration fee: (Check one: \_\_\_ \$125 [Physician] \_\_\_ \$75 [Non-physician])

Form of payment:

- \_\_\_ Check made payable to the **University of Hawaii**  
\_\_\_ Purchase order. P.O # \_\_\_\_\_  
(Must accompany registration)

\_\_\_ I hereby authorize University of Hawai'i the use of my credit card account:

\_\_\_ VISA \_\_\_ MasterCard **Expir. date (Mo/Yr)** \_\_\_\_\_

Credit Card No. \_\_\_\_\_

CVV2 code (last 3 digits on signature strip) \_\_\_\_\_

Signature \_\_\_\_\_

Print name \_\_\_\_\_

Send registration form, payment & Application for Training form to:

UH Conference Center

2530 Dole St., Sakamaki, C403

Honolulu, HI 96822

(808)956-8204 [Phone]; (808)956-3364 [Fax]

UHCC I.D. C09308

Would you like to be contacted for future STD related trainings?

☐ Yes

☐ No



CALIFORNIA  
STD/HIV PREVENTION  
TRAINING CENTER

(Please print within boxes)

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[illegible]

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[illegible][illegible]

1. **Your gender (select one):** ☐ Female<sup>1</sup> ☐ Male<sup>2</sup> ☐ Transgender<sup>3</sup>
2. **Your ethnicity (select one):** ☐ Hispanic or Latino<sup>1</sup> ☐ Not Hispanic or Latino<sup>2</sup>
3. **Your racial background (select one or more):**  
☐ American Indian or Alaska Native<sup>1</sup> ☐ White<sup>4</sup>  
☐ Asian<sup>2</sup> ☐ Native Hawaiian or Other Pacific Islander<sup>5</sup>  
☐ Black or African American<sup>3</sup>

**4. What percentage of your principal occupation is devoted to STD/HIV (select one)?**

☐ None<sup>1</sup>   ☐ 1-25%<sup>2</sup>   ☐ 26-50%<sup>3</sup>   ☐ 51-75%<sup>4</sup>   ☐ 76-99%<sup>5</sup>   ☐ 100%<sup>6</sup>

**5. Your occupation classification (select one):**

☐ Medical/laboratory..... Answer questions 6-9  
☐ Non-medical..... Answer questions 10-14

**6. Your profession (select one):**

<input type="checkbox"/> Advanced practice nurse <sup>1</sup>	<input type="checkbox"/> Physician Assistant <sup>5</sup>
<input type="checkbox"/> Registered nurse <sup>2</sup>	<input type="checkbox"/> Laboratorian <sup>6</sup>
<input type="checkbox"/> LPN/LVN <sup>3</sup>	<input type="checkbox"/> Other <sup>7</sup> : _____
<input type="checkbox"/> Physician <sup>4</sup>	

**7. Your primary functional role (select one):**

<input type="checkbox"/> Clinician <sup>1</sup>	<input type="checkbox"/> Laboratorian <sup>10</sup>
<input type="checkbox"/> Administrator <sup>2</sup>	<input type="checkbox"/> Student <sup>11</sup>
<input type="checkbox"/> Supervisor <sup>3</sup>	<input type="checkbox"/> Faculty <sup>12</sup>
<input type="checkbox"/> Program manager/coordinator <sup>4</sup>	<input type="checkbox"/> Health educator <sup>13</sup>
<input type="checkbox"/> Case manager <sup>5</sup>	<input type="checkbox"/> Trainer <sup>14</sup>
<input type="checkbox"/> Prevention case manager <sup>6</sup>	<input type="checkbox"/> Outreach <sup>15</sup>
<input type="checkbox"/> Counselor <sup>7</sup>	<input type="checkbox"/> Disease intervention/investigation <sup>16</sup>
<input type="checkbox"/> Researcher <sup>8</sup>	<input type="checkbox"/> Not employed <sup>17</sup>
<input type="checkbox"/> Resident/fellow <sup>9</sup>	<input type="checkbox"/> Other <sup>18</sup> : _____

**8. Year of professional graduation (highest level):** \_\_\_\_\_

**9. ☐ Please check here if you are an Indian Health Service, Tribal or Urban Health Care provider.**

Medical/laboratory

**10. Your profession (select one):**

<input type="checkbox"/> Epidemiologist <sup>1</sup>	<input type="checkbox"/> Behavioral scientist <sup>6</sup>
<input type="checkbox"/> Community health worker <sup>2</sup>	<input type="checkbox"/> Counselor <sup>7</sup>
<input type="checkbox"/> Disease intervention specialist <sup>3</sup>	<input type="checkbox"/> Administrator <sup>8</sup>
<input type="checkbox"/> Health educator <sup>4</sup>	<input type="checkbox"/> Mental health therapist <sup>9</sup>
<input type="checkbox"/> Social worker <sup>5</sup>	<input type="checkbox"/> Other <sup>10</sup> : _____

**11. Your primary functional role (select one):**

<input type="checkbox"/> Administrator <sup>1</sup>	<input type="checkbox"/> Student <sup>9</sup>
<input type="checkbox"/> Supervisor <sup>2</sup>	<input type="checkbox"/> Faculty <sup>10</sup>
<input type="checkbox"/> Program manager/coordinator <sup>3</sup>	<input type="checkbox"/> Health educator <sup>11</sup>
<input type="checkbox"/> Case manager <sup>4</sup>	<input type="checkbox"/> Trainer <sup>12</sup>
<input type="checkbox"/> Prevention case manager <sup>5</sup>	<input type="checkbox"/> Outreach <sup>13</sup>
<input type="checkbox"/> Counselor <sup>6</sup>	<input type="checkbox"/> Disease intervention/investigation <sup>14</sup>
<input type="checkbox"/> Researcher/epidemiologist <sup>7</sup>	<input type="checkbox"/> Not employed <sup>15</sup>
<input type="checkbox"/> Resident/fellow <sup>8</sup>	<input type="checkbox"/> Other <sup>16</sup> : _____

**12. Highest level of education (select one):**

<input type="checkbox"/> Some High School <sup>1</sup>	<input type="checkbox"/> Master's Degree <sup>5</sup>
<input type="checkbox"/> High School Graduate <sup>2</sup>	<input type="checkbox"/> Doctoral Degree <sup>6</sup>
<input type="checkbox"/> Technical School Graduate <sup>3</sup>	<input type="checkbox"/> Other <sup>7</sup>
<input type="checkbox"/> Bachelor's Degree <sup>4</sup>	

**13. How many years have you been in your profession?** \_\_\_\_\_

**14. How many years have you been at your current organization?** \_\_\_\_\_

Non-medical

**15A. Your principal employment setting (select one):**

- |  |  |
|--|--|
| <input type="checkbox"/> State/local health department <sup>1</sup>              | <input type="checkbox"/> Tribal/Indian Health Service <sup>8</sup>                 |
| <input type="checkbox"/> Solo/group private medical practice <sup>2</sup>        | <input type="checkbox"/> School/university (academic department) <sup>9</sup>      |
| <input type="checkbox"/> HMO/managed care organization <sup>3</sup>              | <input type="checkbox"/> School/university (student health clinic) <sup>10</sup>   |
| <input type="checkbox"/> Hospital or hospital-affiliated clinic <sup>4</sup>     | <input type="checkbox"/> Capacity-Building Assistance (CBA) provider <sup>11</sup> |
| <input type="checkbox"/> Community/non-profit health center/clinic <sup>5</sup>  | <input type="checkbox"/> Military <sup>12</sup>                                    |
| <input type="checkbox"/> Community-based service organization (CBO) <sup>6</sup> | <input type="checkbox"/> Not employed <sup>13</sup>                                |
| <input type="checkbox"/> Correctional facility <sup>7</sup>                      | <input type="checkbox"/> Other <sup>14</sup> : _____                               |

**15B. If your principal employment setting is a Community Based Organization (CBO), please specify how your agency is primarily funded (select one):**

- ☐ Directly funded by CDC – program announcement 04064<sup>1</sup>
- ☐ Directly funded by CDC – program announcement 03003<sup>2</sup>
- ☐ Other CDC program announcement (please specify)<sup>3</sup>: \_\_\_\_\_
- ☐ Health department<sup>4</sup>
- ☐ Other<sup>5</sup>: \_\_\_\_\_

**15C. If your organization receives CDC funding to provide Capacity Building and Technical Assistance (CBA), please specify how your agency is primarily funded (select one):**

- ☐ Directly funded by CDC - program announcement 05051<sup>1</sup>
- ☐ Directly funded by CDC - program announcement 04019<sup>2</sup>
- ☐ Other CDC program announcement (please specify)<sup>3</sup>: \_\_\_\_\_
- ☐ Health department<sup>4</sup>
- ☐ Other<sup>5</sup>: \_\_\_\_\_

**16. Primary programmatic focus of your work (select up to two):**

- |   |   |
|---|---|
| <input type="checkbox"/> STD <sup>1</sup>                                 | <input type="checkbox"/> Substance use/addiction <sup>7</sup> |
| <input type="checkbox"/> HIV/AIDS <sup>2</sup>                            | <input type="checkbox"/> Emergency medicine <sup>8</sup>      |
| <input type="checkbox"/> Women's reproductive health <sup>3</sup>         | <input type="checkbox"/> Corrections <sup>9</sup>             |
| <input type="checkbox"/> General medicine or Family practice <sup>4</sup> | <input type="checkbox"/> Infectious Disease <sup>10</sup>     |
| <input type="checkbox"/> Adolescent health/Pediatrics <sup>5</sup>        | <input type="checkbox"/> Internal Medicine <sup>11</sup>      |
| <input type="checkbox"/> Mental health <sup>6</sup>                       | <input type="checkbox"/> Other <sup>12</sup> : _____          |

**17. Special population(s) or target group(s) focused on by your work/program (select up to three):**

- |   |  |
|---|--|
| <input type="checkbox"/> No target group/general <sup>1</sup>           | <input type="checkbox"/> Asians <sup>10</sup>                                  |
| <input type="checkbox"/> Adolescents <sup>2</sup>                       | <input type="checkbox"/> Native Hawaiian/other Pacific Islanders <sup>11</sup> |
| <input type="checkbox"/> Gay/Lesbian/Bisexual/MSM <sup>3</sup>          | <input type="checkbox"/> American Indian/Alaska Native <sup>12</sup>           |
| <input type="checkbox"/> Transgender <sup>4</sup>                       | <input type="checkbox"/> Hispanic/Latinos <sup>13</sup>                        |
| <input type="checkbox"/> Homeless <sup>5</sup>                          | <input type="checkbox"/> Recent immigrants/refugees <sup>14</sup>              |
| <input type="checkbox"/> Incarcerated individuals/parolees <sup>6</sup> | <input type="checkbox"/> Substance users/IDU <sup>15</sup>                     |
| <input type="checkbox"/> Pregnant women <sup>7</sup>                    | <input type="checkbox"/> Substance users/non-IDU <sup>16</sup>                 |
| <input type="checkbox"/> Sex workers <sup>8</sup>                       | <input type="checkbox"/> HIV+ individuals <sup>17</sup>                        |
| <input type="checkbox"/> African Americans <sup>9</sup>                 | <input type="checkbox"/> Other special population <sup>18</sup> : _____        |

**18. If you are applying for Continuing Education Credits, indicate type (please check with PTC to determine type of CEUs offered for a specific course):**

- |   |  |
|---|--|
| <input type="checkbox"/> Medical (CME) <sup>1</sup> | <input type="checkbox"/> CET <sup>4</sup>              |
| <input type="checkbox"/> Nursing (CH) <sup>2</sup>  | <input type="checkbox"/> Behavioral (BBS) <sup>5</sup> |
| <input type="checkbox"/> CHES <sup>3</sup>          | <input type="checkbox"/> CAADAC <sup>6</sup>           |
|   | <input type="checkbox"/> Other <sup>7</sup> : _____    |

Certification/License Number: \_\_\_\_\_

**19. How did you hear about this course (select one primary source)?**

- |  |   |
|--|---|
| <input type="checkbox"/> Flyer/brochure <sup>1</sup>               | <input type="checkbox"/> Conference exhibit <sup>6</sup>  |
| <input type="checkbox"/> Word of mouth/colleague <sup>2</sup>      | <input type="checkbox"/> Previous PTC course <sup>7</sup> |
| <input type="checkbox"/> E-mail <sup>3</sup>                       | <input type="checkbox"/> Program requirement <sup>8</sup> |
| <input type="checkbox"/> Notice in newsletter/journal <sup>4</sup> | <input type="checkbox"/> Other <sup>9</sup> : _____       |
| <input type="checkbox"/> Website/internet <sup>5</sup>             |   |

**20. Do you consent to being contacted for\*:**

- A. Updates? ☐ Yes<sup>1</sup> ☐ No<sup>2</sup>
- B. Evaluation purposes? ☐ Yes<sup>1</sup> ☐ No<sup>2</sup>

\* Frequency of correspondence from the CA PTC averages  
1-3 times a year